

24-HOUR EMERGENCY DETENTION FORM

(Detainment after transfer to a designated psychiatric facility shall not exceed 24 hours. Del. Code Title 16 §5122 rev. 10/09/2014)

Eligibility & Enrollment Unit 302.255.9458

Crisis Intervention Services 800.652.2929

Fax copy of this completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.255.4416. Outside business hours, please fax to 302.255.9952

Section I. REQUEST for 24-HOUR EMERGENCY DETENTION of an ADULT

(To be completed only by a Peace Officer or Credentialed Mental Health Screener.)

I,			of theUnit and/or		
	PRINT Full Name / Title		Unit and/or	Agency	
	on this Date/	<u>/</u>	and at this time	::	_ AM / PM
do here	by certify that I have knowledge thatNan			//	/
	Nan	ne of person to be evaluated		D.O.B (mm/dd/yy	yyy) Age
of					
	Address of the residence	of the person to be evaluated (Street, City, State, Zip Co	de)	
	rs to have a mental condition, and quires immediate care, treatment		ms likely to cause d	anger to him o	r herself, or others,
	n I, Questions 1 and 2 shall be concreener must annotate as needed	-	<u>-</u>		
1. <u>As</u>	sessment of Dangerousness:				
١	"Dangerous to self" means that be will imminently sustain serious boomistory, recent behavior, and any re	lily harm to oneself. This			
ı	"Dangerous to others" means that will inflict serious bodily harm upon a account a person's history, recent be	another person within the	<i>immediate future.</i> Th		
	"Serious bodily harm" means phys disfigurement, significant impairmen				
á	a. Does this person meet the	requirement for dange	rousness to self?	YES [] NO □
	and	1 / or			
I	b. Does this person meet the	requirement for dange	rousness to others	? YES	□ NO □

ame of Person being evaluated:		D.O.B//			
Describe / instifuthe descriptions finding noted	in nace one.				
Describe / justify the dangerousness finding noted g.g., Describe any stated or observed suicidal intent/action, any stated or		ction, and/or any stated or observed dangerous			
ehavior by said person, and/or any stated or observed symptom of a me					
a. What is the name, relationship, and contact infor	mation for person who i	placed the initial call for help:			
First and Last name of reporting party	Relationship	() Phone			
	·				
b. Why does the person require a Mental Health As	sessment for a 24-Hour	Emergency Detention?			
(Include specific details to support a finding of dangerousness to	nclude specific details to support a finding of dangerousness to self or others due to risk of suicide, homicide, or impaired mental condition.				
·					
·					
* Please attach and sign additional sheets with addition	nal information, names,	and contact information as needed.			
-					
Signature / Title or rank of person submitting this Request for Evaluation	///	: AM / PM			
		· ····································			
Contact phone number of person submitting request	Agency				
2 2 p. 101 5. poroon odomining roquoti					

Name of Persor	n being evaluated: D.O	.B	/	_/
Section II.	Assessment of Apparent Mental Condition			
"Mental con judgment, ca "mental con traumatic et	ndition" means a current, substantial disturbance of thought, mood, perception or orientation apacity to control behavior or capacity to recognize reality. Unless it results in the severity of indition" DOES NOT mean simple alcohol intoxication, transitory reaction to drug ingestion, dericiologies or other general medical conditions, Alzheimer's disease, or intellectual disability. The psychosis" or "active psychosis," but shall include all conditions that result in the severity of in	mpairmo mentia c e term m	ent describ lue to vario nental cond	ned herein, ous non- dition is not
	ove-named person is displaying behaviors meeting criteria for a mental (and/or in SECTION 1, on page 1 and 2 of this form, above)	tal cor	ndition (see above) as
2. ☐ YES, the p	person is NOT WILLING or ABLE to seek safe, appropriate treatment on hi	s/her o	own at th	nis time.
3. Does this per	rson have an Advanced Mental Health Care Directive?	YE	ES □ NO	D
3. Does this per		YE	ES □ NO	D
3. Does this per 4. a. Has the pe	rson have an Advanced Mental Health Care Directive?	YE	ES □ NO	
3. Does this per 4. a. Has the pe b. If <i>YES</i> , whe 5. a. Is the perso	rson have an Advanced Mental Health Care Directive?	YE	ES NO	Unknown Unknown Unknown Unknown Unknown
3. Does this per 4. a. Has the pe b. If YES, whe 5. a. Is the pers b. If YES, prov 6. a. Does the p b. If YES, name	rson have an Advanced Mental Health Care Directive? erson been admitted to a psychiatric hospital before? ere and when (if known) was the person previously admitted?: on receiving current out-patient mental health treatment? vide the doctor and/or therapist and/or provider's names and phone numbers: person have a care manager? me of manager, phone number, and agency:	YE YE YE YE	ES NO	Unknown D Unknown D Unknown D Unknown D Unknown D Unknown D
3. Does this per 4. a. Has the pe b. If YES, whe 5. a. Is the pers b. If YES, prov 6. a. Does the p b. If YES, nam c. Has Provide 7. a. Does the p	erson have an Advanced Mental Health Care Directive? erson been admitted to a psychiatric hospital before? ere and when (if known) was the person previously admitted?: on receiving current out-patient mental health treatment? vide the doctor and/or therapist and/or provider's names and phone numbers: person have a care manager?	YE	ES NO	Unknown Unknown Unknown Unknown Unknown Unknown
3. Does this per 4. a. Has the pe b. If YES, whee 5. a. Is the person b. If YES, prov 6. a. Does the p b. If YES, nam c. Has Provide 7. a. Does the p b. If YES, wha	erson have an Advanced Mental Health Care Directive? erson been admitted to a psychiatric hospital before? ere and when (if known) was the person previously admitted?: on receiving current out-patient mental health treatment? vide the doctor and/or therapist and/or provider's names and phone numbers: person have a care manager? me of manager, phone number, and agency: er been contacted? YES NO If NO, please explain why not: person currently use mind-altering substances (drugs, alcohol, meds, etc.)	YE YE YES	ES NO	Unknown Unknow
3. Does this per 4. a. Has the pe b. If YES, whee 5. a. Is the person b. If YES, prov 6. a. Does the p b. If YES, nam c. Has Provide 7. a. Does the p b. If YES, wha	erson have an Advanced Mental Health Care Directive? erson been admitted to a psychiatric hospital before? ere and when (if known) was the person previously admitted?: on receiving current out-patient mental health treatment? vide the doctor and/or therapist and/or provider's names and phone numbers: person have a care manager? ne of manager, phone number, and agency: er been contacted? YES NO If NO, please explain why not: person currently use mind-altering substances (drugs, alcohol, meds, etc.) at substances and when last used: phone number of spouse, closest relative, or peer support (if known) of	YE YE YE YES	ES NO	Unknown Unknown Unknown Unknown Unknown Unknown

Section III. CREDENTIALED SCREENER 24-HOUR EMERGENCY DETENTION STATEMENT

rtify that I, am a Credentialed Mental Health Screener, #			
personally assessed that this person,	,	//	
	Name of person evaluated	D.O.B (mm/dd/yyyy)	
_	ET the standard for 24-hour detention: experiencing and/or others by reason of mental condition. (See a	• •	
This person was offered voluntary in	n-patient treatment and:		
is UNABLE to self-determine nee	ed for treatment.		
REFUSED voluntary treatment a	t this date/time: //	@:AM / PM	
has AGREED* to voluntary treat	Date (mm/dd/yyyy) ment. *(If person is now voluntarily agreeing to treatme	Time (hh/mm) ent, please complete page 5 of this form.	
I am a licensed Emergency Medicine I am a physician licensed in the state I am a Licensed Mental Health Profe	ice medicine in the state of Delaware. Doctor and a DSAMH Credentialed Mental Health Screen of Delaware to practice medicine or surgery and a DSAM essional or Registered Nurse and also a DSAMH Credential ofessional, a DSAMH credentialed Mental Health Screene	MH Credentialed Mental Health Screener led Mental Health Screener.	
This person is being taken to:	e of Facility or Address of Alternate Location		
Name	e of Facility or Address of Alternate Location		
I have notified the nearest known r	relative.		
	relative,Name of relative / significant other	and phone (if different than page 2)	
YES NO Specify reaso			
Specify reaso	n not notified		
I certify that the information I am p	roviding is true and complete to the best of my kno	owledge.	
		AM / DM	
Signature	///	AM / PM Time (hh / mm)	
- 9	_ =====================================		
Title/necition	Employed by	() Unit Telephone	
Title/position	Employed by	onit relephone	
SECTION IV. CONFLICT of I	INTEREST STATEMENT		
Del. Administrative Code, Title 16, Reg detained for any reason other than exp others, and that any conflicts of interes and 24-hour Emergency Admission form file monitor all assessments, detentions ar	g 6002, Sec. 6.1 Conflict of Interest Statement: The intent of periencing symptoms associated with a mental condition that st as set forth in 16 Del.C. §5122 are disclosed on the DSAMI ed with DSAMH within 24 hours of signature of the detentioned non-detentions performed by credentialed mental health es of ensuring that the intent of this law is met and that admired the statement of this law is met and that admired the statement of this law is met and that admired the statement of this law is met and that admired the statement of this law is met and that admired the statement of the statement of the intent of the statement of t	at may result in danger to self or H Crisis Intervention Assessment Tool on order. DSAMH will collect and a screeners, whether a conflict of	
Conflict of Interest Disclosure State	ment: No conflicts Yes, as follows:		
· · · · · · · · · · · · · · · · · · ·	duly disclosed any conflicts of interest and I have made contact as to the nature and quality of the person's mental discontact.		
Cimpatura	//	: AM / PM	
Signature	Date (mm/dd/yyyy)	Time (hh / mm)	

SECTION V. **CHANGE in STATUS** Name of Person being evaluated: _____ D.O.B. ____/ ___/ ____ a. Certification of Understanding: This section shall only be used if a person who is currently emergently detained requests voluntary admission for inpatient mental health treatment. If a person is found to meet the criteria for voluntary admission pursuant to this section, that person shall have the status of "voluntary" upon arrival at a designated psychiatric treatment facility. A person who is emergently detained shall not have his or her status converted to "voluntary" if the person continues to be a danger to self or danger to others due to an apparent mental condition and such person appears unable or unwilling to remain in care ending the person's placement at designated psychiatric treatment facility. A change in status pursuant to this section shall not be used to discharge a person from care. Only a psychiatrist has the authority to discharge person who is emergently detained. I have read the above statement and certify that I understand. Signature Position/ Title Facility / Hospital b. Assessment for Voluntary Admission: I have personally assessed the individual and I certify that the individual has the capacity to fully understand and appreciate the terms of voluntary admission for inpatient mental health treatment, including: (1) The person will not to be allowed to leave the hospital grounds without permission of the treating psychiatrist Yes No 🗌 (2) If the person seeks discharge prior to the discharge recommended by the person's treatment team, the person's treating psychiatrist may initiate the involuntary inpatient commitment process if the psychiatrist believes the individual presents a danger to self or danger to others Yes 🗌 No 🗌 (3) Unless the involuntary commitment process is initiated, the person will not have the hospitalization reviewed by the **Superior Court** Yes 🗌 No 🗌

If "NO" is selected for any of the above questions the 24-hour emergency detention may not be converted to voluntary admission

(Continue to next page)

Name of Person being evaluated:	D.O.B/	D.O.B//		
c. My assessment is based upon the fo	ollowing direct observations:			
c. My assessment is based apon the N	onowing direct observations.			
Please describe the steps being taken to treatment facility for continued care and		ill be transferred to a designated	J psychiatric	
I certify that based upon my personal a admission for inpatient mental health t admission. Yes No				
	/	::	AM / PM	
Signature	Date (mm/dd/yyyy)	Time (hh/mm)		
Position/ Title	Facility / Hospital			
I OSIGOT/ TIGE	i acility / i lospital			

Name of Person be	eing evaluated:		D.O.B/	/
SECTION VII.	DISCHARGE: (May	ONLY be COMPLETED by a	PSYCHIATRIST)	
I certify that the ab	ove-named individual no	longer meets the criteria for emerg	gency detention, for the follo	owing reasons:
		//		AM / DM
Signature		Date (mm/dd/yyyy)	Time (hh/mm)	AM / PM
Position/ Title		Facility / Hospital		
	leted form to DSAMH Eligibility s, please fax to 302.255.9952	y and Enrollment Unit during business ho ?	ours, MonFri., 7 a.m3 p.m. to 30)2.255.4416.
Thi	s form is to be forwarded	to the receiving hospital with the	transporting officer or desi	gnee.
Section VIII.	STATEMENT of PEA	CE OFFICER or DESIGNATED	D TRANSPORTER:	
l,		have transported,		
with all reasonab for further evalua		nated psychiatric treatment facility	/,	,
		//	::	AM / PM
Signature of Offic	cer or Transporter	Date (mm/dd/yyyy)	and Time (hh/mm)	
Print Full Name			 Transport Agency Name	
	Attach Request f	or Transportation Reimbursement		